OFFICE OF THE CORONER
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2008 Annual Report

Mission Statement:

"The Summit County Office of the Coroner will ensure that statutory responsibilities are followed by objective and thorough investigation as to the Cause and Manner of death with compassion; while professional, experienced staff help bring answers, closure and understanding to those left behind."

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2008 DATA SUMMARY

- There were a total of 56 cases:
- 42 were male or 75%
- 14 were female or 25%
- 15 of these cases were autopsied or 27%
- Saturday was the busiest day of the week with 11 cases.
- The most dispatched time was between 4p-5pm. 26 in the am hours and 29 in the pm hours.
- January was the busiest month with 8 cases followed by Feb, Ap, & Dec with 7.
- There were 5 hospice cases
- 4 cases were accepted for tissue or organ donation out of 14 referrals
- There were 9 transfer cases: 8 accepted from other jurisdiction, 1 back to Clear Creek Co.
- 28 cases were Natural in manner or 50%
- 21 cases were Accidental in manner or 38%
- 4 cases were Suicides
- 1 was Undetermined.
- 1 Homicide (transferred back to Clear Creek County)

CHART

As you can see the monthly case load is unpredictable and 2006 was the busiest year on record.

Cases By Month Breakdown: Blue JR **Red (prior to current administration)**

Year	Jan	Feb	Mar	Ap	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	C#	a
1999	6	10 16	4 20	4 24	0 24	6 30	3 33	4 37	3 40	3 43	3 46	4	50	28
2000	8	2 10	5 15	2 17	1 18	6 24	3 27	4 31	2 33	4 37	6 43	4	47	24
2001	5	5 10	4 14	10 24	3 27	3 30	4 34	3 37	4 41	2 43	5 48	2	50	39
2002	3	2 5	5 10	5 15	2 17	4 21	3 24	4 28	4 32	2 34	7 41	5	46	22
2003	7	3 10	8 18	6 24	3 27	0 27	6 33	3 36	2 38	2 40	4 44	3	47	25
2004	5	2 7	13 20	3 23	2 25	2 27	5 32	3 35	3 38	5 44	2 45	5	50	18
2005	9	5 14	5 19	2 21	3 24	3 27	5 32	3 35	1 36	5 41	4 45	5	50	13
*2006	11	8 19	8 27	2 29	3 32	6 38	8 46	4 50	5 55	5 60	3 63	7	70	25
2007	5	5 10	3 13	3 16	1 17	3 20	4 24	4 28	5 33	1 34	2 36	6	42	13
2008	8	7 15	4 13	7 24	3 29	3 32	4 36	3 39	4 43	4 47	2 49	7	63	14

INTRODUCTION 2008

The Coroner's office is a separate and independent entity within the Summit County Government and is funded through the Summit County Commissioners by the citizens of Summit County. Summit County is considered a Category II. County; the second most populated Category in Colorado. The state legislature sets the Coroner's Salary. The Coroner's office makes body removals and there is a cooler at the local hospital. Autopsies are done in Jefferson County. The Coroner's office works with local law enforcement on joint field death investigations and is responsible for determining when an autopsy is needed and for certifying the cause of death. The office further understands the catastrophic effects that death has on those left behind and is committed to performing a complete investigation into the circumstances surrounding the death. This can sometimes take several weeks or more.

The Coroner is an elected position, voted into office by Summit County Citizens. There are term limits in place of no more than three (4-year) terms. The elected Coroner, Joanne Richardson, has been a certified paramedic since 1985 and worked in Maine, New York and Baltimore as such. In 2006, she became the only Coroner in Colorado to become a Board Certified Fellow in Medicoloegal Death Investigation through the American Board of Medicoloegal Death Investigators. Three are three other Deputy Coroner's in Colorado who have earned this achievement and one is the Chief Deputy Coroner for this office. In 2007, the Summit County Office of the Coroner became the only office in Colorado to become accredited by the International Association of Coroner's & Medical Examiners. In 2008, Richardson earned a Master's Degree in Forensic Science & Investigation from National University and in 2010 earned a Master's Certification in Bereavement Studies.

The office is staffed with five deputies who work on a prn (as needed) basis and have to be on the schedule a minimum of 4 days a month. The Coroner attends an average of 70% of the cases and reviews deputy coroner reports. There is no administrative staff so the Coroner is responsible for day to day office administration as well as making sure the office has available staff 365 days a year, 24-hours-a day.

RESPONSIBILITIES

The Coroner must direct the work of the sworn and non-sworn personnel and the functions of the office. Plans, organizes, directs, and reviews the activities of the office and makes suggestions for a short and long range planning and objective goal setting. The Coroner is responsible for field or inter office operations and to supervise and personally perform investigations and administrative duties.

Death Notifications are also part of the Coroner's responsibility and this office is also responsible for notifying next of kin of the death of a loved one which can be a challenge since many next are out of the county, state or country. In all cases an effort is made to have this notification performed in person by sending another coroner or police officer to the next of kin before phoning which is a last resort. We find that phoning is impersonal and causes more distress if there is no support with the person receiving the news. We have the luxury of having less than 70 cases a year and we can take the time to do this.

The Coroner is responsible for creating and implementing written guidelines, objectives and office priorities; including yearly budgets. Further responsibilities include long range planning including mass fatality planning. Assisting the Forensic pathologist if asked or attends autopsy and is required to maintain a proper chain of custody with all evidence from autopsy and investigation. The Coroner monitors the legislation for new laws. The Coroner is represents the office at meetings, enhancing communication and training to public service entities and the public. Other responsibilities include, recognizing the need for consultation in toxicology, dental identification, entomology and other forensic specialties. The Coroner must recognize when third parties must be consulted including the Occupational Safety Health Administration (OSHA), Drug Enforcement Administration, Consumer Product Safety, discovery of skeletal remains and so forth. The Coroner is responsible for working with the media and participates in quarterly and yearly statistical reporting programs. The Coroner coordinates and manages programs and special projects. Special projects have been assigned to deputies including data base data retrieval and archiving old records.

Under statute CRS 30-10-601.8 requires that “each coroner shall complete a minimum of sixteen hours of in-service per year" and this office requires the same of deputy coroners. We often exceed this amount.

Under statute (CRS 30-10-606) which states the following cases are to be investigated: These include but are not limited to:

1. ALL victims of homicide or suspected homicide;
2. ALL victims of suicide or suspected suicide;
3. ALL persons dead on arrival (DOA) at a hospital;
4. ALL victims of accidental death or suspected accidental death;
5. ALL persons dying in vehicular accidents (auto, motorcycle, boat etc);
6. ALL "crib deaths" (SUIDI/SUIDIC)
7. ALL cases of overt or suspected child abuse;
8. ALL persons dying in aircraft accidents;
9. ****ALL patients that expire within 24 hours of admission to any hospital; HOWEVER, if any surgical procedure performed it IS considered a Coroner's Case by this office.
10. ALL cases in which a physician is not in attendance, OR when, though in attendance, the physician is unable to certify the cause of death.
11. ALL cases where a physician has not seen the decedent within forty-five (45) days of death. In any case where death occurred without medical attendance solely because the deceased was under treatment by prayer or spiritual means alone in accordance with tenets and practices of a well-recognized church or religious denomination. (In all of these cases, however, contact the Coroner);
12. ALL deaths of unexplained causes, suspicious circumstances, or if the death was the result of traumatic means.
13. ALL deaths occurring while the decedent is in police custody or during transport;
14. ALL cases of recovery of skeletal remains;
15. ANY case wherein there is such postmortem decomposition that a sufficient investigation and external examination to rule out injuries cannot be made and where the circumstances of the death do not enable one to rule out other than natural causes;
16. ALL industrial or employment accidents;
17. ALL deaths by poison or suspicion of poison;
18. ALL cases where the victim dies suddenly when in apparently good health;
19. ALL deaths associated with diagnostic or therapeutic procedures;
20. ANY patient who has sustained an injury (fracture, fall, concussion, etc.) prior to or during hospital admission and;
21. Exhumations (disinterment) performed for the purpose of establishing the cause of death or clearing up a question relating to the cause of death.

COUNTY OVERVIEW

The Coroner's Office serves a population of 29,626 and covers 606 square miles. Summit County is a popular tourist destination with four Ski Resorts, biking, hiking, climbing and the like. Over 11,000,000 cars and trucks travel through the Eisenhower Tunnel annually. There is no airport or rail system in Summit County. We average 50-70 cases a year.

EXPLANATION OF DATA

In the last 7 years we have seen an increase of local residents as opposed to tourists which used to outnumber county residents in deaths. The data represents a compilation of yearly statistics of deaths reported to our office and includes information about manner, cause of death, alcohol or drug involvement, and information about violent deaths which include homicides, traumatic injury due to accidental or suicidal means.

When drugs or alcohol are included in the data, it means that the levels exceeded therapeutic drug levels or were over the legal alcohol limit. The common drugs which were found are listed beneath the table.

You will see tables which give the total number of cases investigated by this office, autopsies ordered, day and hour of day most dispatched, cases by month, age, gender, where the decedent was from, area of the county our office responded to, police jurisdiction, scene type, manner, common natural cause, activity at time of death, snow sport deaths, motor vehicle crashes, drug and alcohol deaths and suicide data.

AUTOPSY - A detailed postmortem external and internal exam which includes toxicology and microscopic exam to determine cause of death.

CAUSE OF DEATH - The agent of effect which results in a physiological derangement incompatible with life. The results of the medicoloegal death investigation combined with scene investigation combined with information about medical history, toxicology or X-ray examination, autopsy and circumstances surrounding the death serve to establish the cause of death. The cause of death can result from different circumstances and manner of death. For example the same cause of death, drowning can result from the accidental submersion of a child in a bathtub or from the homicidal immersion in a bathtub. Scene investigation is vital.

CIRCUMSTANCES OF DEATH - The situation, setting or condition present at the time of injury or death.

DONOR - Cases from our office in which organ or tissue donation was accepted. Many times our referrals for donation exceed the number of cases accepted. Decline for donation is usually due to body not being found for 24 hours or more, IV fluid or blood product resuscitation drug abuse history, or refusal for religious reasons.

HOSPICE - These are expected deaths due to known disease process.

MANNER OF DEATH - The general category of the condition, circumstances or event which causes the death. There are 6 manners recognized in Colorado:

Natural - The manner of death used when a disease is the sole cause of the death. If death is hastened by an injury such as incurred in a ski crash, the manner of death is not considered natural. Conversely, a driver in a motor vehicle crash may have crashed due to a medical event which would mean the cause of death was natural, not accidental.

Accidental - The manner of death used when in other than natural deaths, there is no evidence of intent. This category includes motor vehicle crashes (MVC), some overdoses (circumstance and level dependent), recreational activities, carbon monoxide (CO) or any number of unintentional occurrences.

Suicide - The manner of death in which death results from the intentional harm (explicit or implicit) to one's self.

Homicide - The manner of death in which death results from the intentional harm (explicit or implicit) of one person by another.

Undetermined - The manner of death for deaths in which there is insufficient information to assign a manner. This may include the discovery of skeletal remains. It may include a death where circumstances could point to accident or suicide but there is not enough evidence to assign a manner. Occasionally, autopsies fail to render a manner because no cause of death can be found. In these instances it *usually* means 'probable natural causes' but no disease process was found and there was no evidence of foul play or other means.

Fetal - The designation used for death certificates in fetal death which do not receive an actual manner designation (Certificates of Fetal Demise).

PRIMARY SCENE - Refers to the place of death or the initiating factor causing the death originated at this scene.

SECONDARY SCENE - Refers to a body dump site (not where death occurred), or at the primary scene during transport or at a medical facility. This might include a motor vehicle crash victim taken by ambulance to the local hospital. This means that we may have 'two scenes'. We will go to the crash site investigate circumstances before we go to the hospital.

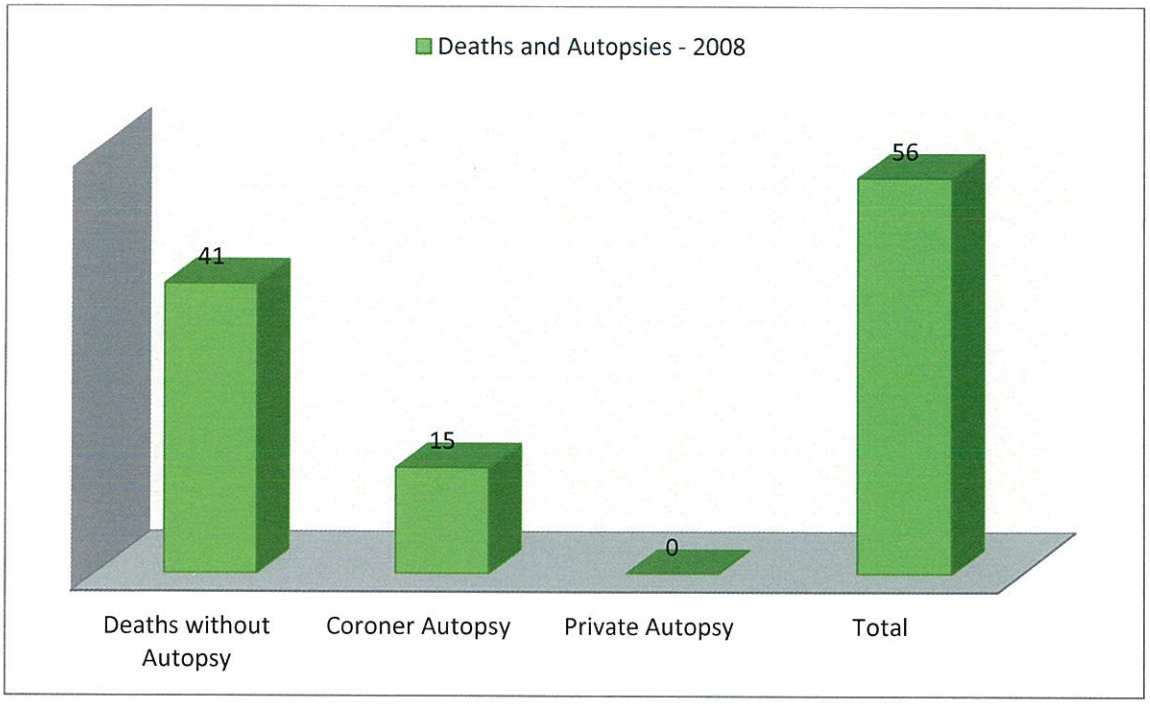
TRANSFER OF JURISDICTION - The initiating factor causing the death begins in Summit County but the decedent is taken out of county (Denver area hospital) and succumbs to their injuries there. The victim of

an MVC or ski crash who is transferred by medical personnel to Denver; where they die hours or days later. This office accepts the case back and will obtain information about the place of occurrence or primary scene.

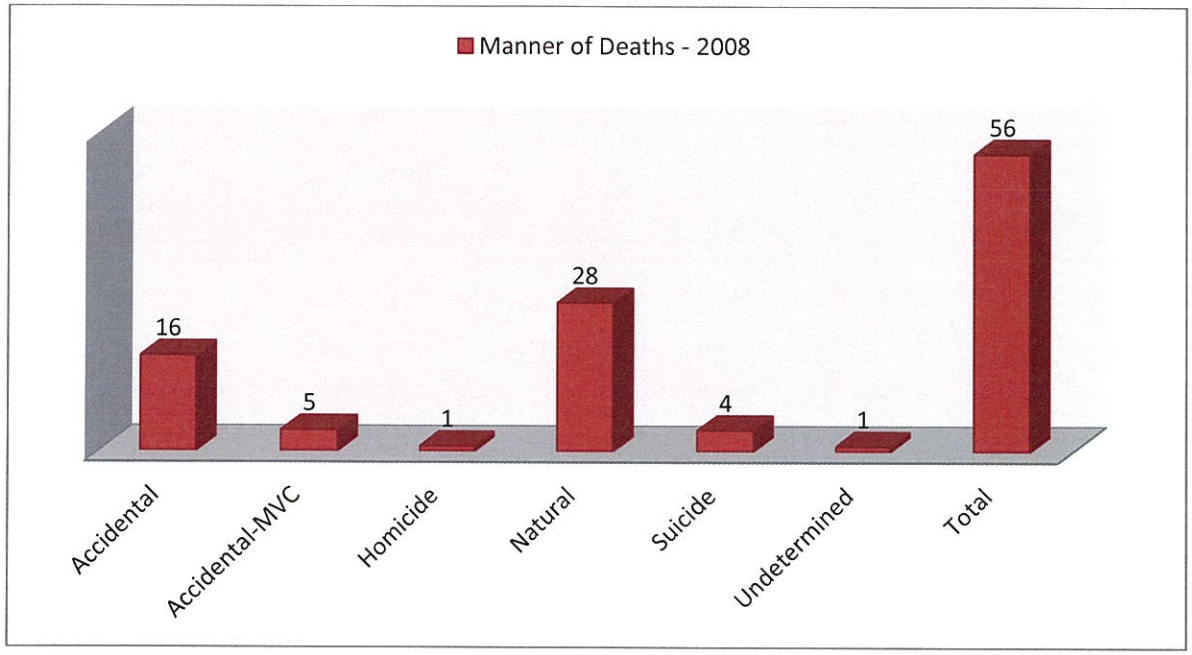
MVC = Motor Vehicle Crash

TOD = Time of Death

Total Number of Deaths & Autopsies



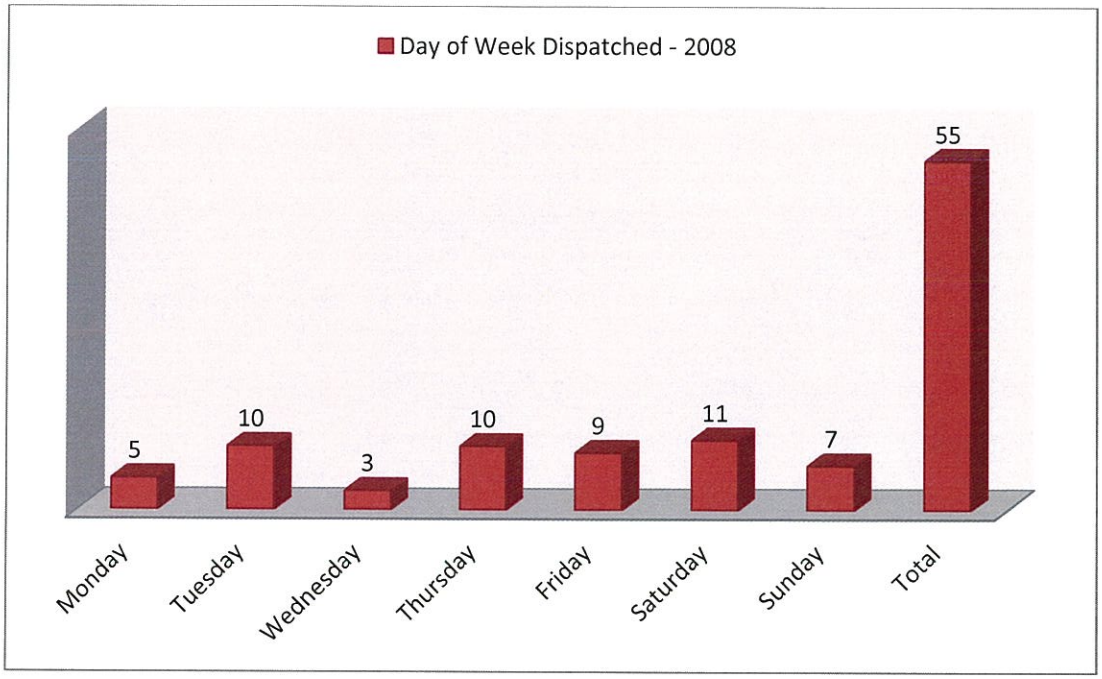
Manner



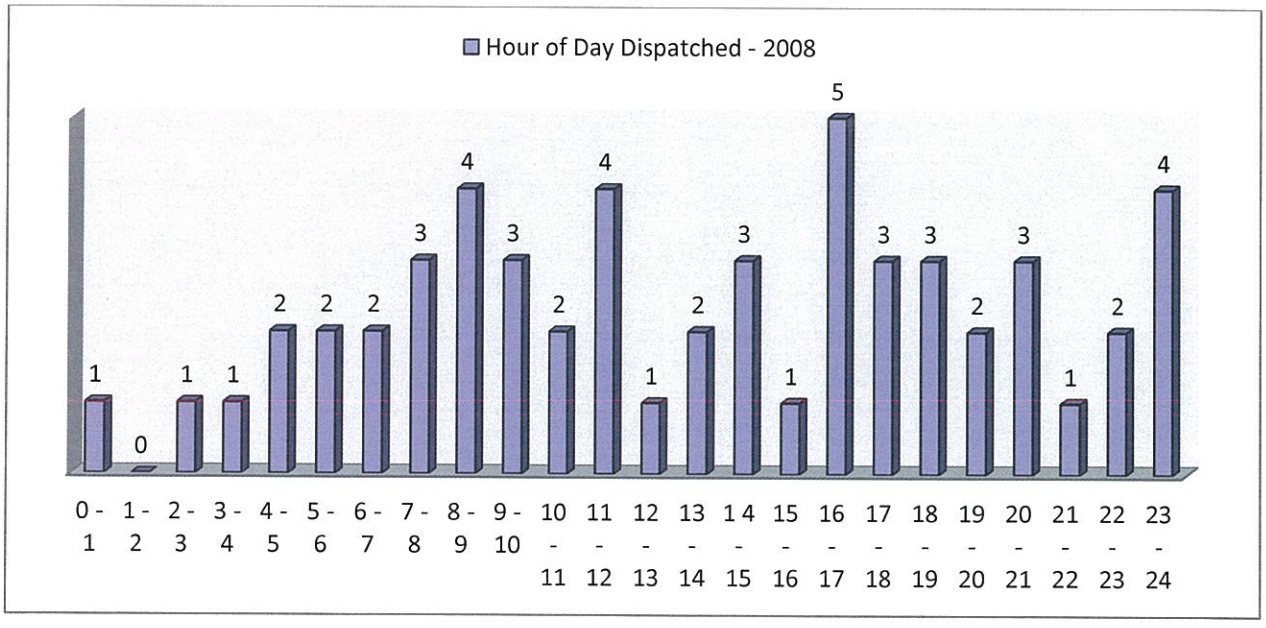
28 Natural
21 were Accidental
- **4 were Motor Vehicle related**
- **1 Motorcycle crash**
- **9 were ski or snowboard related**
- **1 Fire**
- **2 Fall**
- **2 Drown** (Bathtub & Green Mtn. Res)
- **2 Overdose**

4 Suicides
1 Homicide (Transfer back to Clear Creek County)
1 Undetermined (Boat Incident)

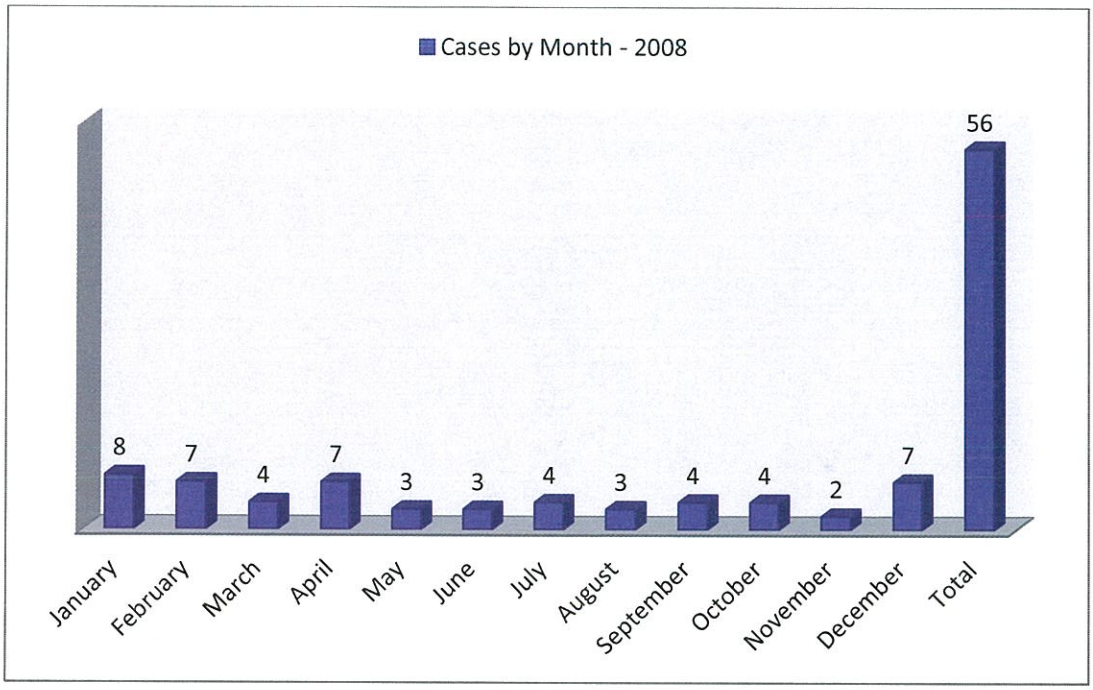
Day of Week



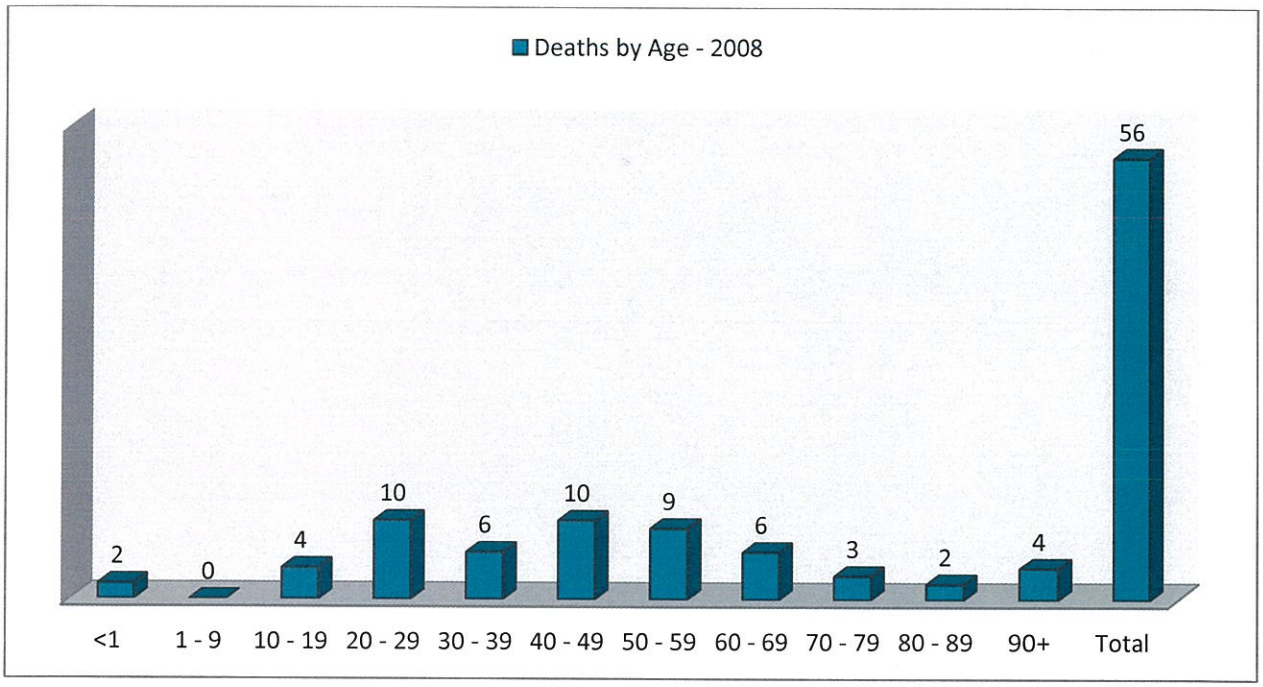
Hour of Day



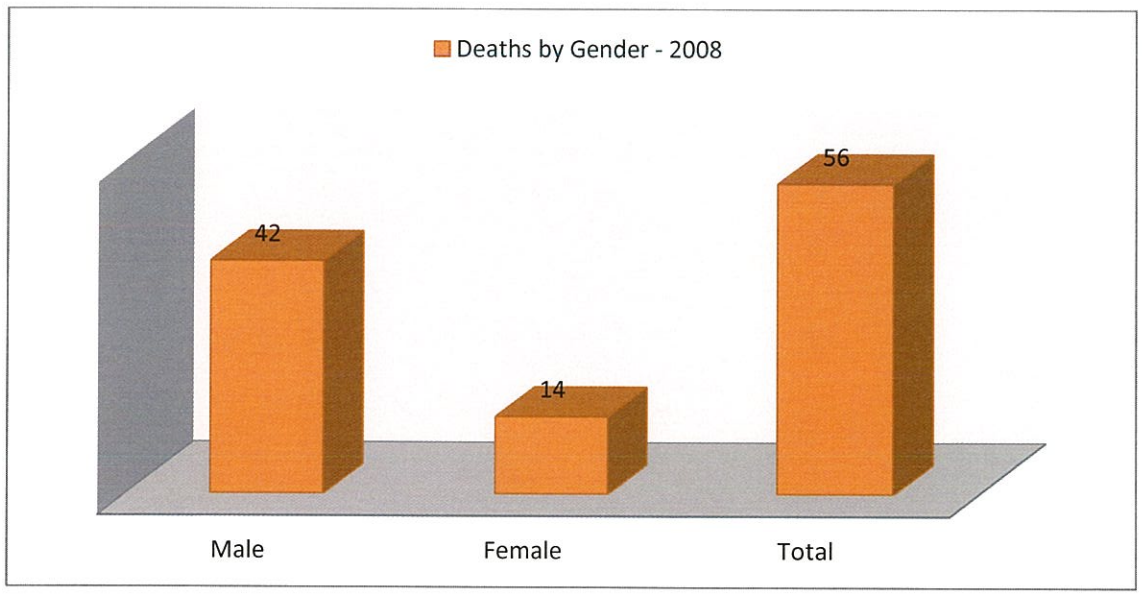
Number of Cases per Month



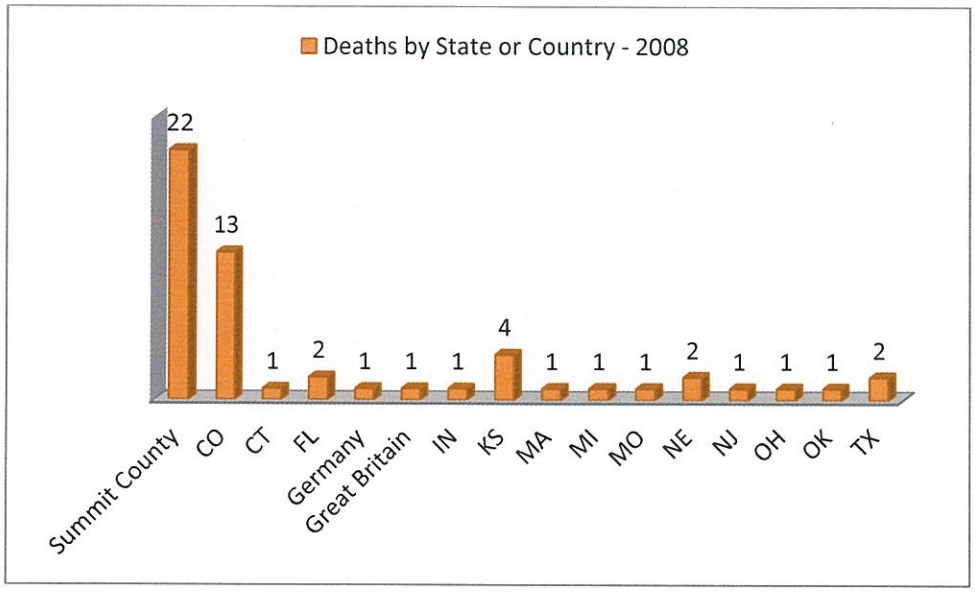
Age Range


Deaths by Age - 2008
2
0
4
10
6
10
9
6
3
2
4
56
<1
1 - 9
10 - 19
20 - 29
30 - 39
40 - 49
50 - 59
60 - 69
70 - 79
80 - 89
90+
Total

Gender



Residency

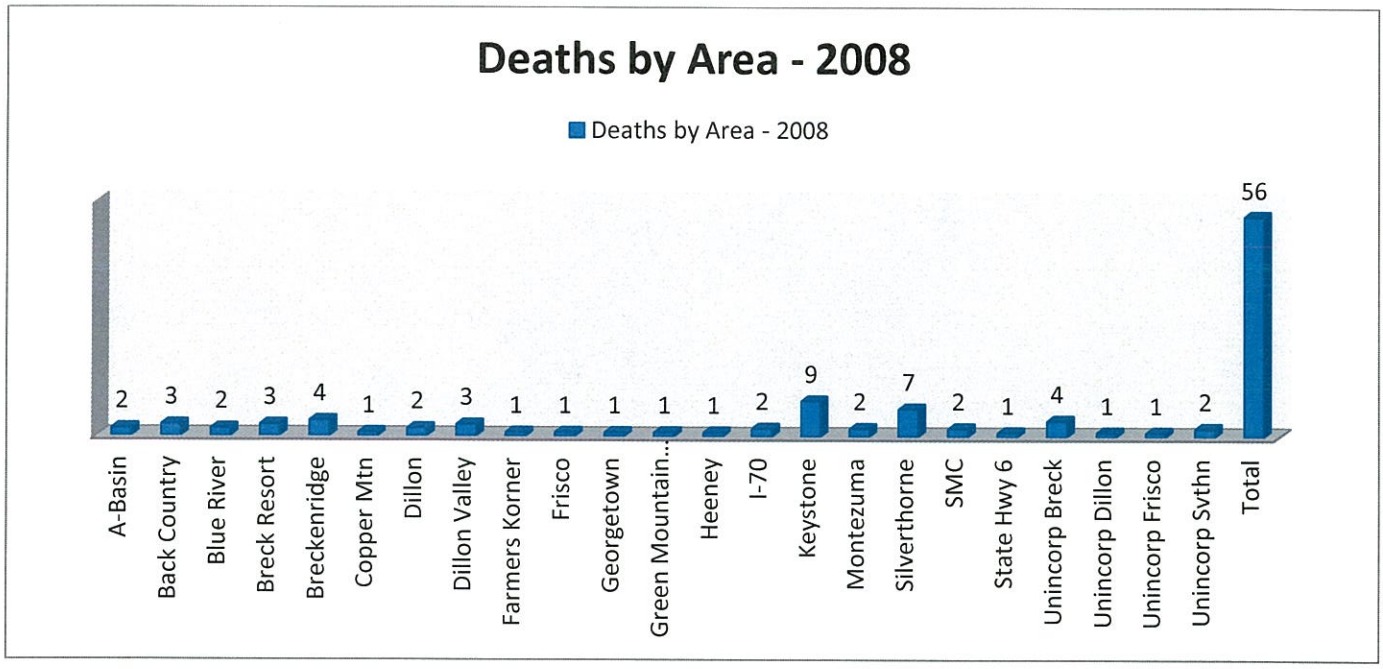


Out of 56 deaths, 22 were Summit County Residents

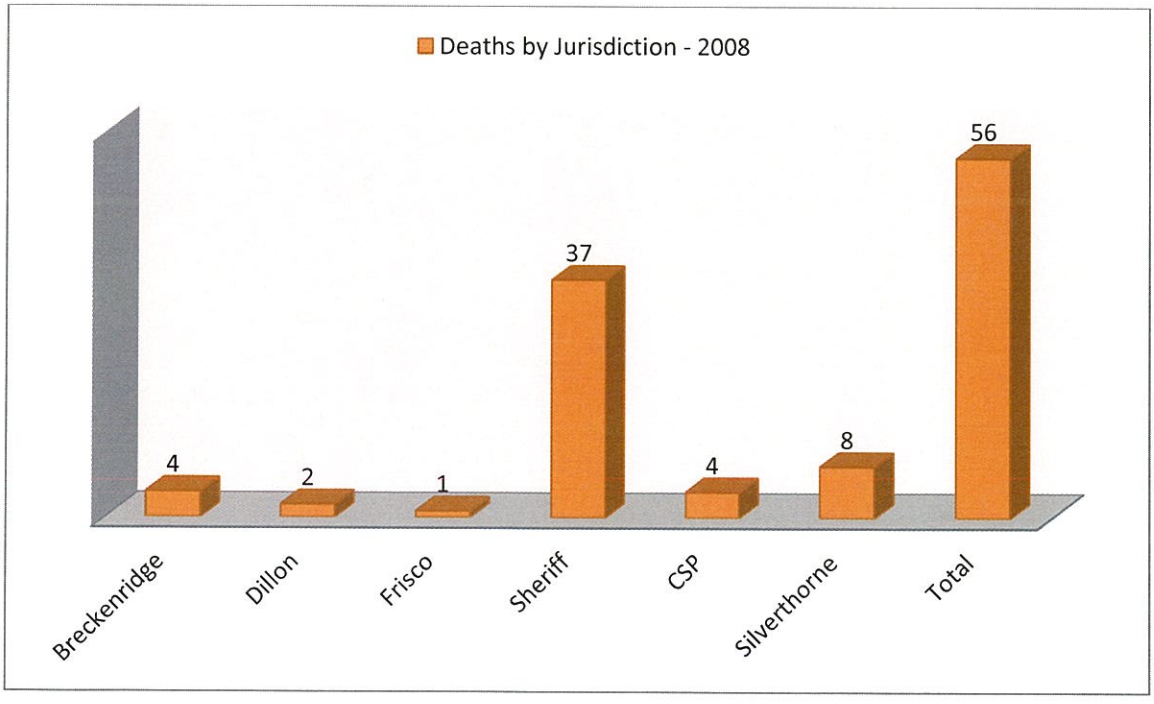
13 were from other parts of Colorado

2 from out of country- Germany & Great Britain

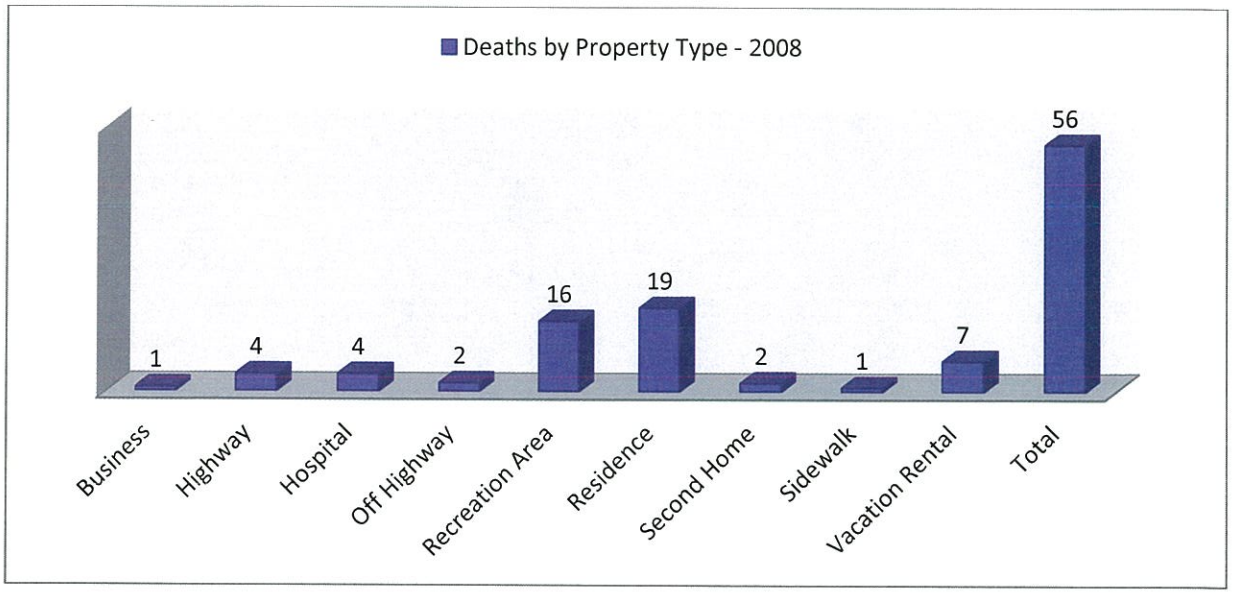
Scene Location



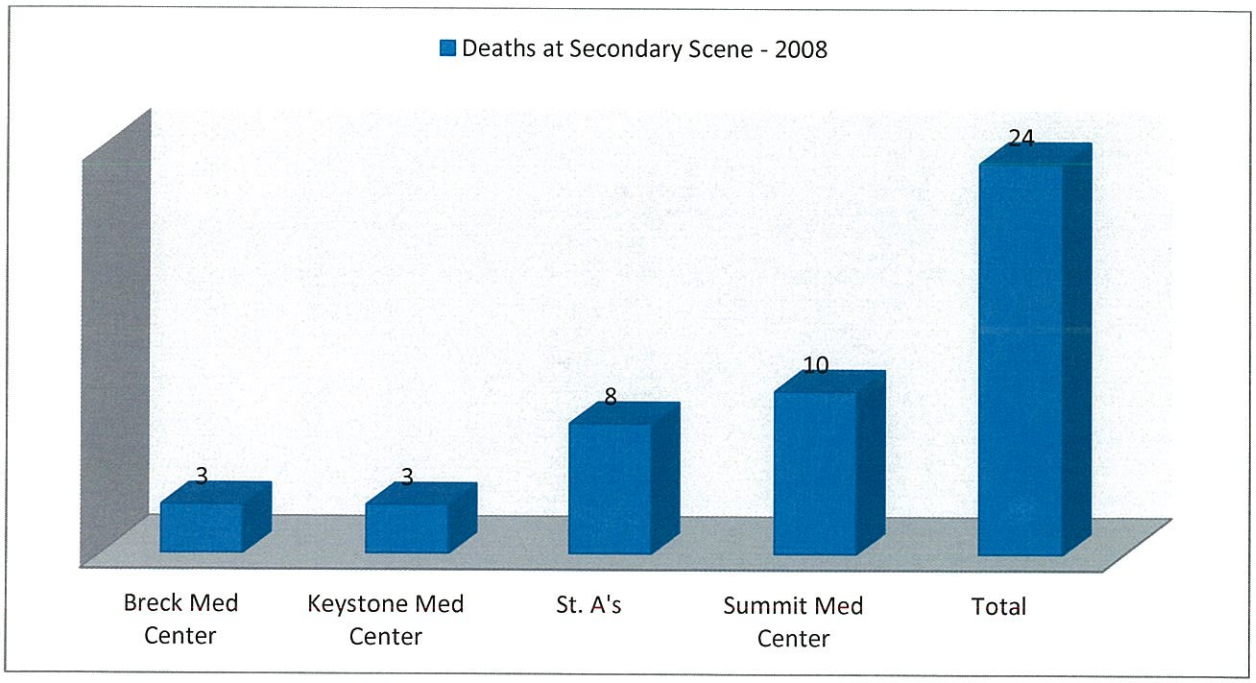
Law Enforcement Jurisdiction



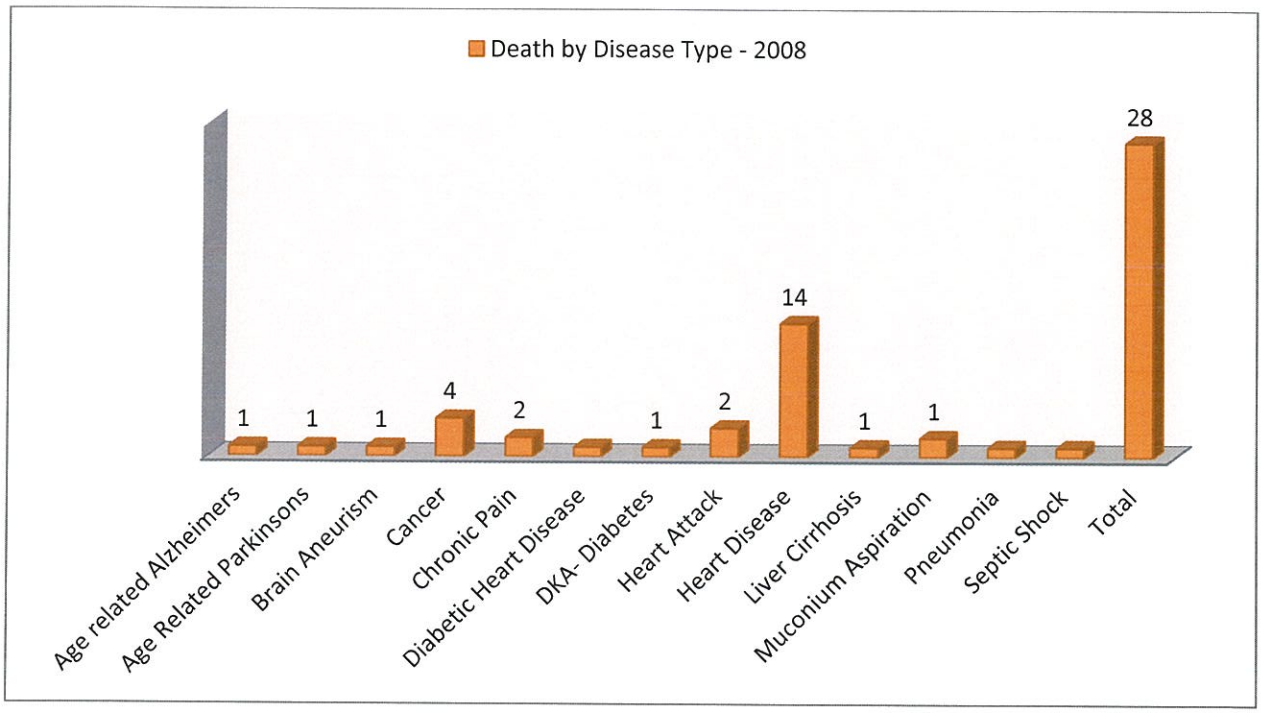
Primary Scene

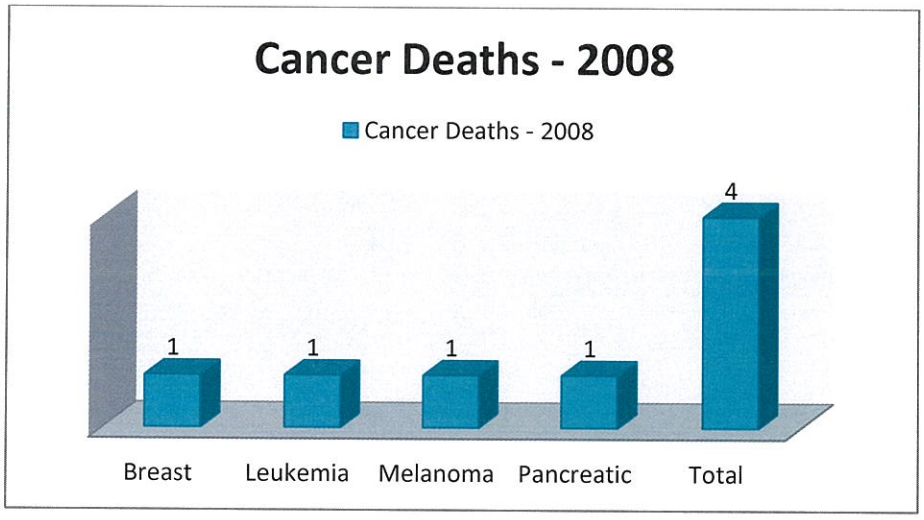


Secondary Scene

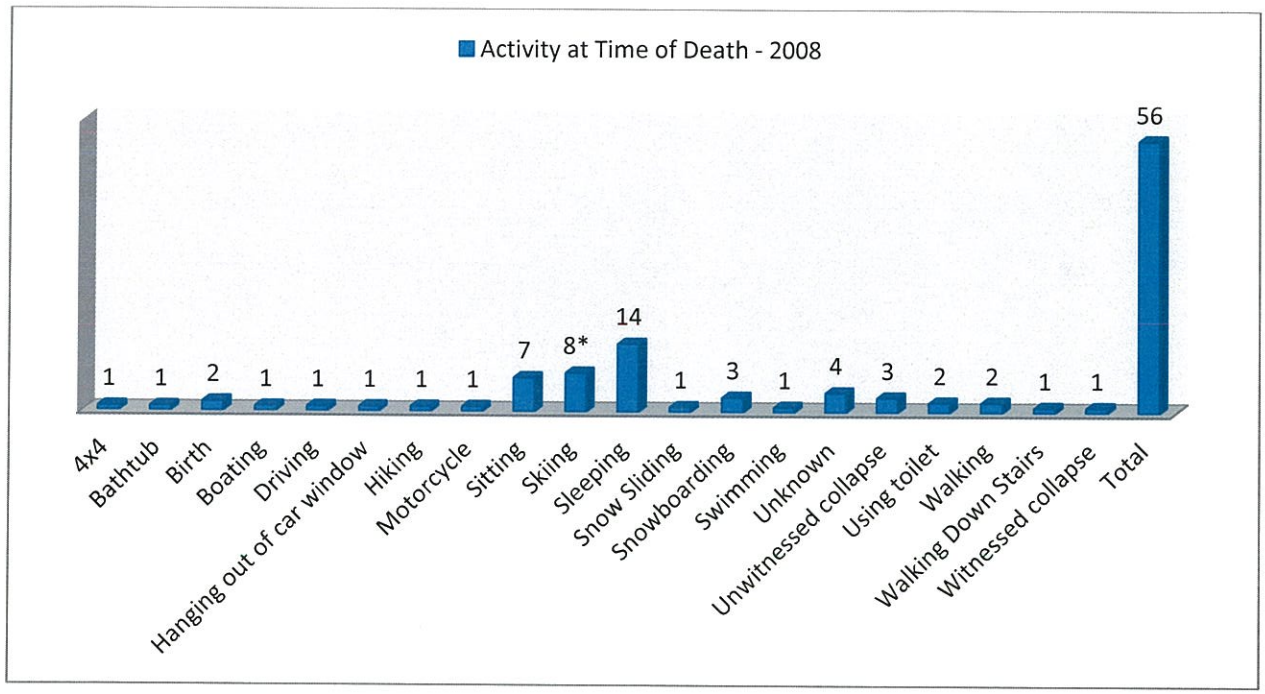


Natural Causes

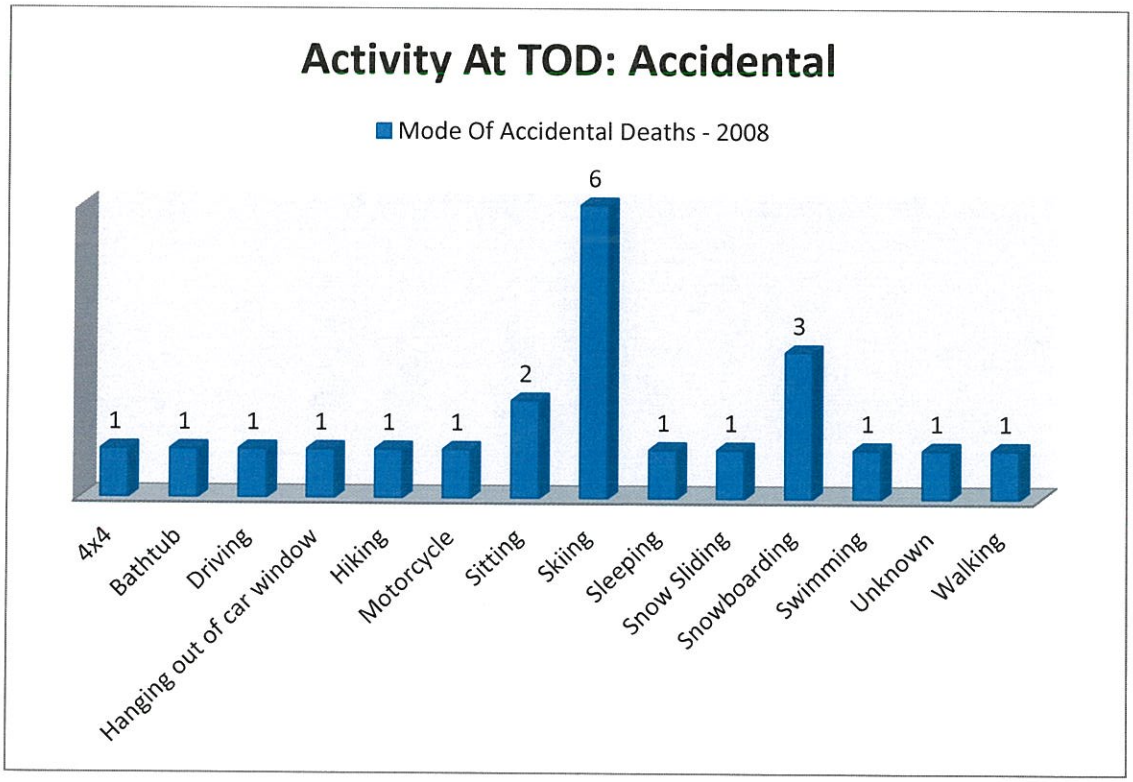




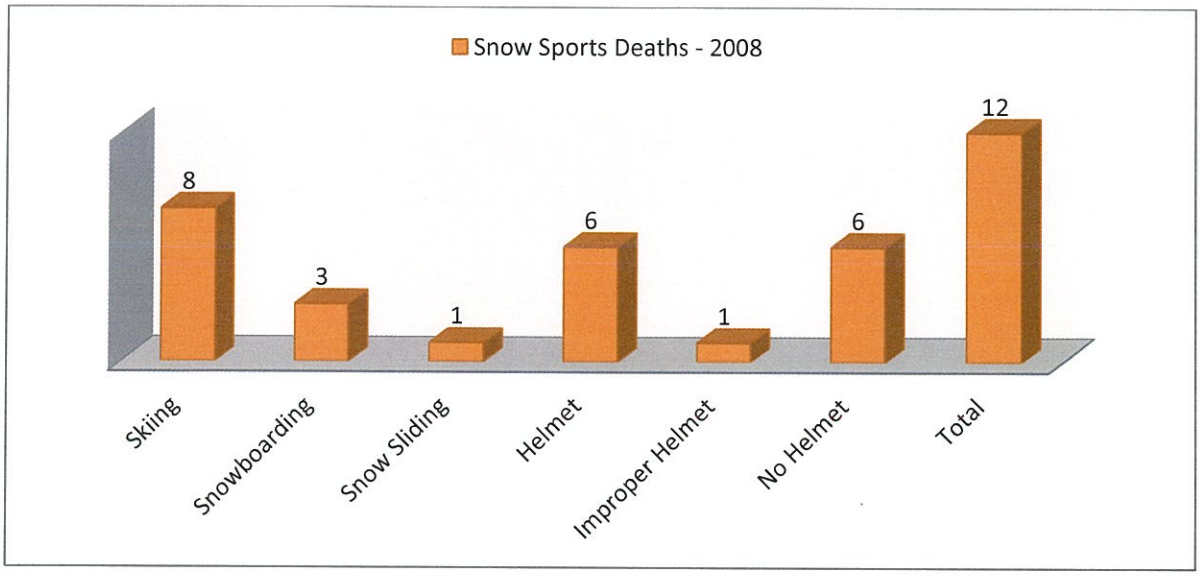
Activity at Time of Death All Manners



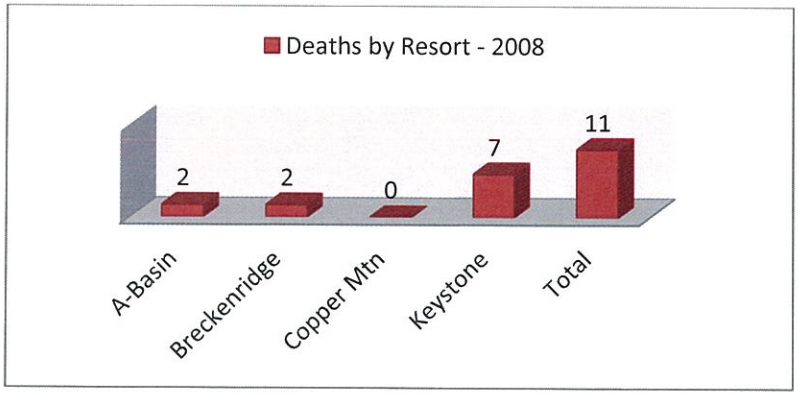
*** 2 Skiers died of natural causes while on the mountain.**



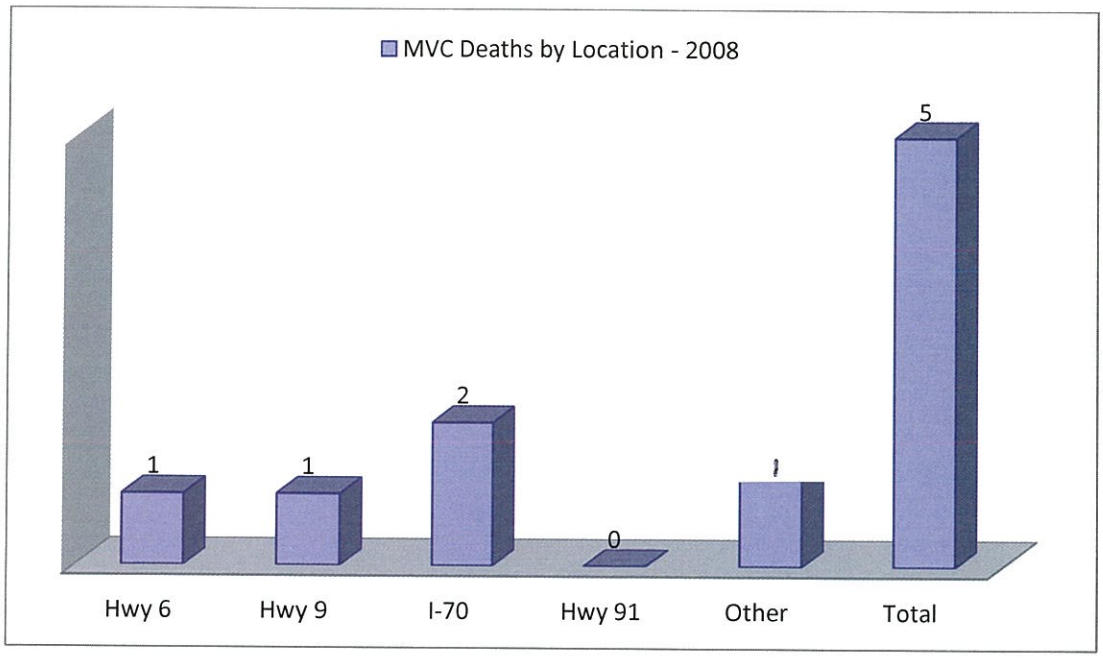
Snow Sports Deaths/Helmeted



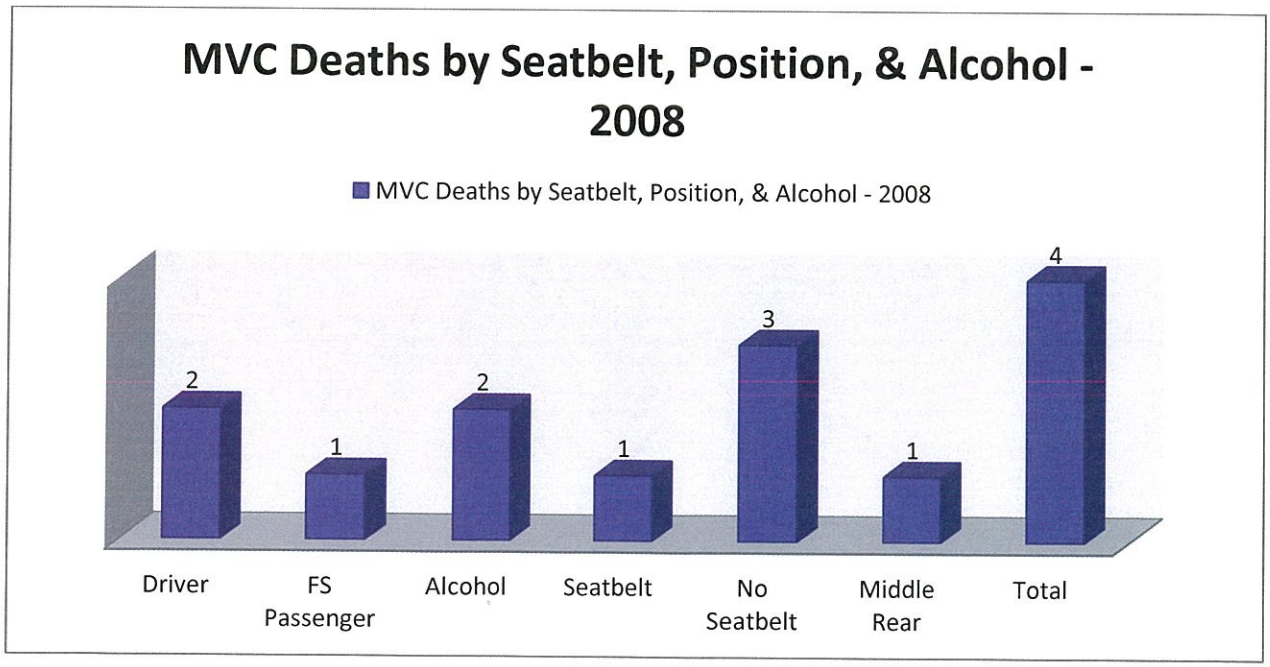
ACTIVITY AT TOD	Helmet	Improper Helmet Type
Skiing	YES	YES (skateboard helmet)
Snowboarding	YES	NO
Skiing	NO	NO
Skiing	YES	NO
Skiing	NO	NO (Natural)
Skiing	YES	NO
Skiing	YES	NO
Snowboarding	NO	NO
Skiing	YES	NO (Natural)
Snow Sliding	NO	NO (Backcountry)
Skiing	NO	NO
Snowboarding	NO	NO



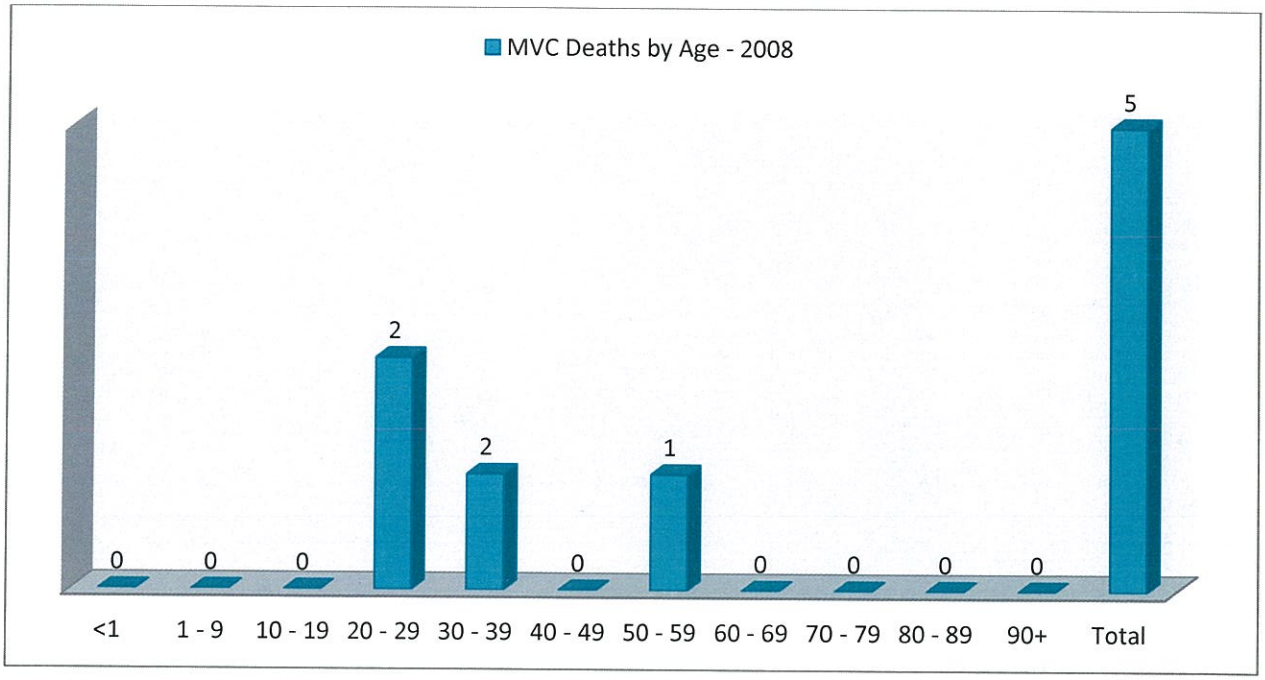
Motor Vehicle Crashes -Location



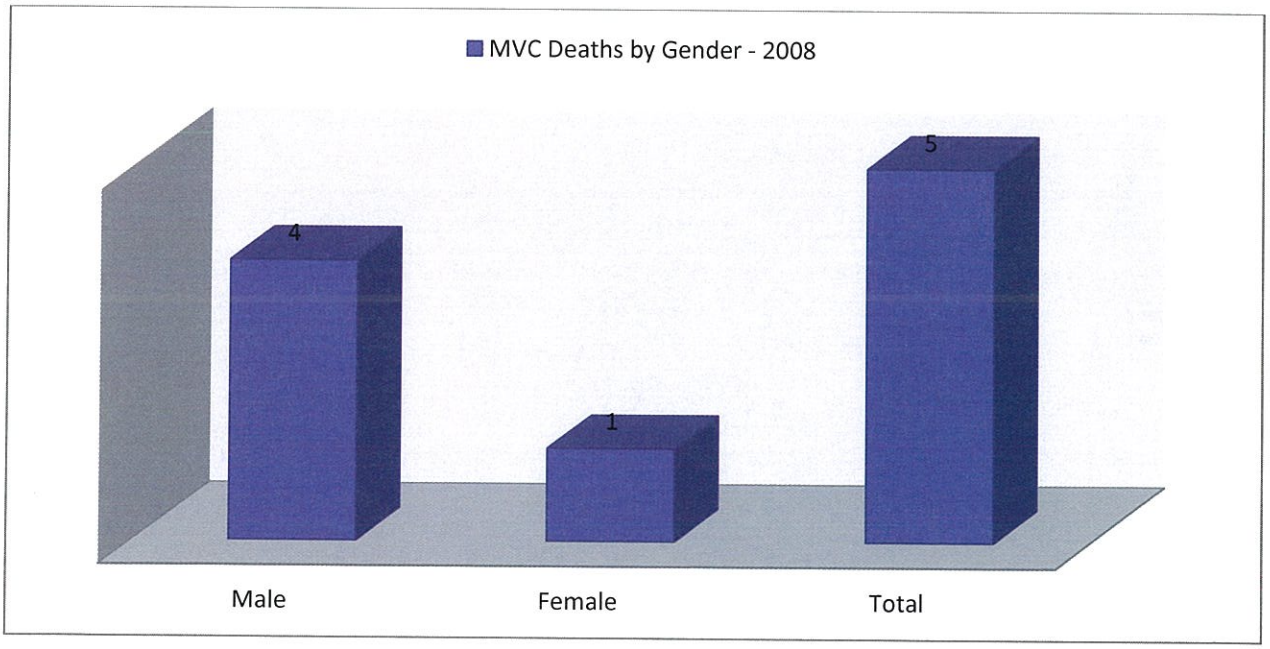
1 Motorcycle crash	**Farmers Korner (Hwy 9)**
MVC	**WB I-70 mile marker 213 (driver)**
MVC	**EB I-70 MM 212.2 (driver)**
MVC	**Hwy 6 MM 215.4 (fell from veh)**
MVC (other)	**Wise Mountain 4x4 Jeep (ejection)**



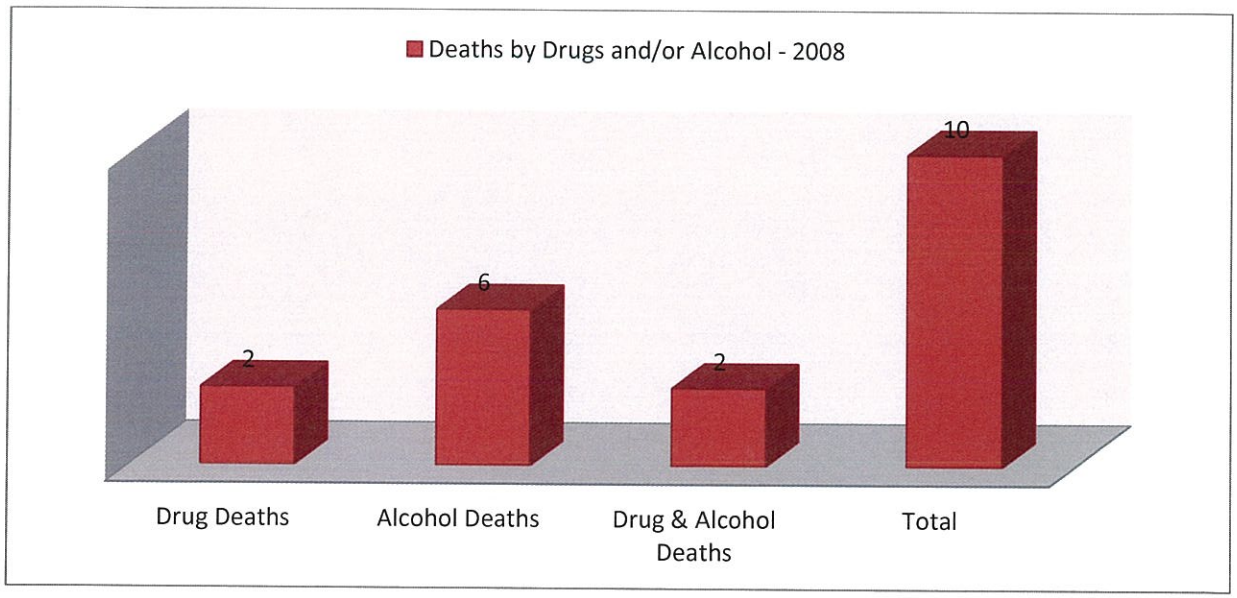
MVC: Age



MVC: Gender



Drugs and Alcohol Related Deaths

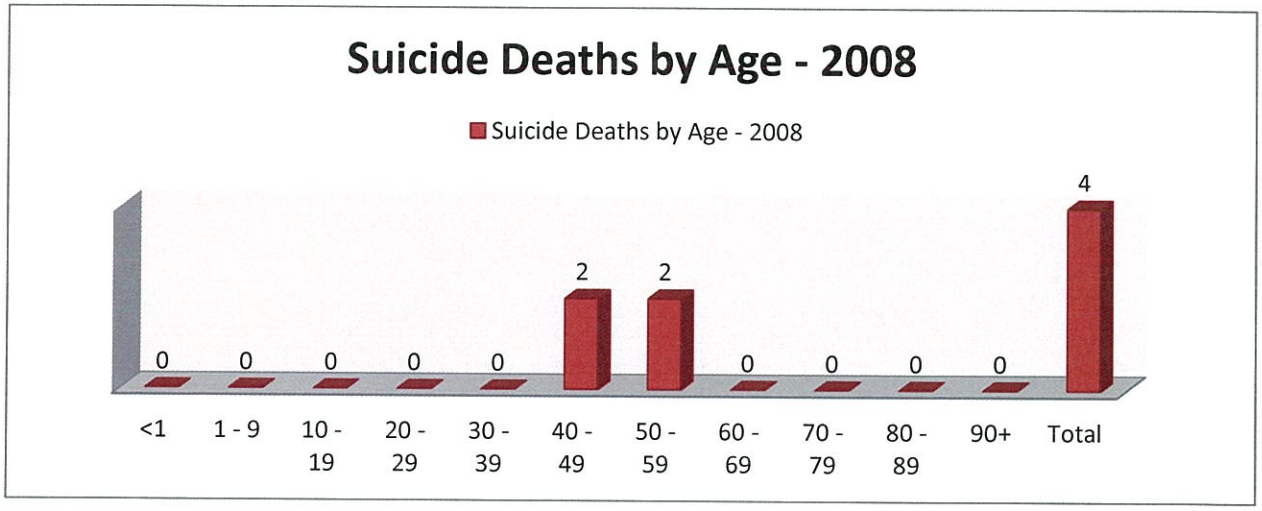


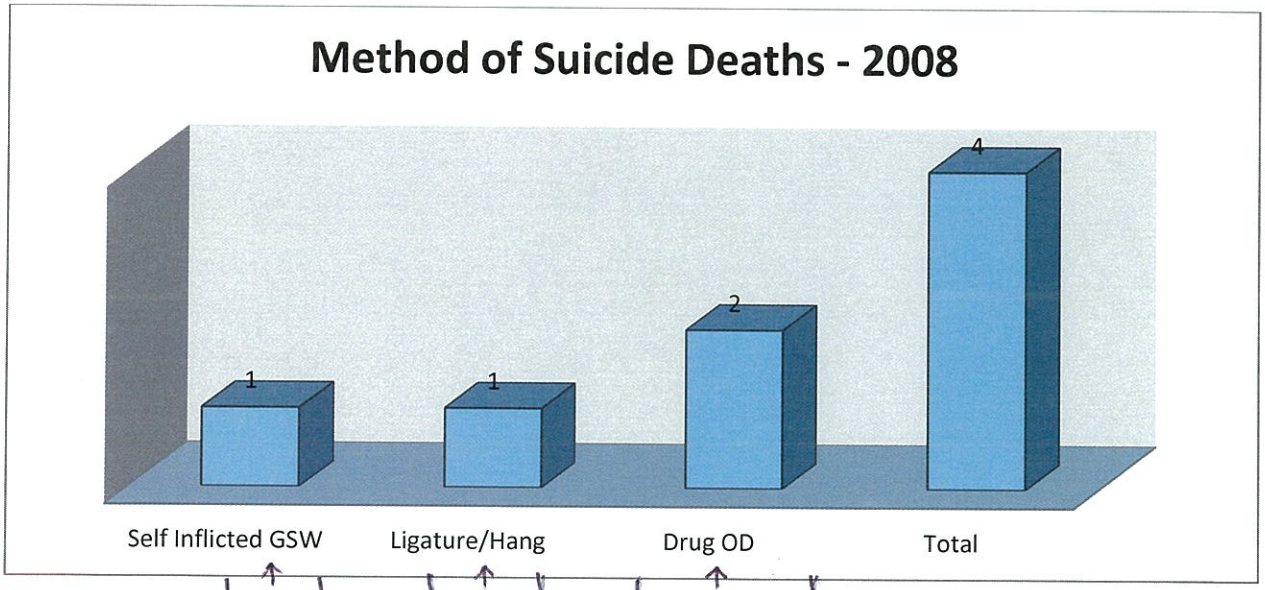
DRUGS FOUND

6 Alcohol, 2 tested + for cannabis

1Cocaine + Morphine (accidental OD)
1Cocaine + Oxycontin (accidental OD)
1Fentanyl Amytriptylline (Suicide) 1Citaloprai
1Fentanyl Prozac (Suicide)

Suicide: Age, Method, Gender





GENDER | **1F** | **1M** | **1M/1F**